

In order for this application to be considered for Financial Assistance, ALL of the following documents are required, if applicable

- ► Completed and signed Financial Assistance Application form
- ► A copy of the **2013** Federal Income Tax return with W-2's and Schedules
- ► A copy of current pay stubs (13 weeks)
- ► A copy of social security, disability, or unemployment checks or award letter
- ▶ A copy of a state AHCCS/Medi-Cal Decision/Denial Notice aka Notice of Action letter. You can obtain this by contacting the Medi-Cal office in the area in which you live. All potentially eligible patients must provide a valid "Notice of Action" from AHCCS/Medi-Cal stating completion of the application and the reason for acceptance or denial. Any Notice of Action stating a failure to provide information or failure to participate in the interview will not be accepted in consideration of this Application for Financial Assistance.
- ▶ 3 months of current bank statements (checking and savings)

Please return your completed application with all requested forms to the following address within 10 days.

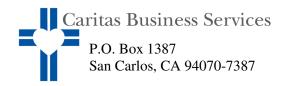
Caritas Business Services
Attn: Financial Assistance Coordinator
P O Box 1387
San Carlos, CA 94070-7387

Contact our billing office, Caritas Business Services, at 866-899-9626, if you have any questions.

Please be advised this in not a guarantee that financial assistance will be awarded; and payments should continue on a regular basis until a determination has been made. Your application and the information provided will be reviewed and verified and a decision will be provided to you in writing.

Thank you for your cooperation. We look forward to being of assistance to you to resolve your account.

Return by this Date:
Account Number:
Account Balance:



Account:

Patient Name:

CHARITY CARE AND FINANCIAL ASSISTANCE APPLICATION

LAST NAME (PATIENT) FIRST		MIDDLE	SOCIAL SECURITY #	BIRTHDATE			
RESIDENCE ADDRESS (FACILITY ADDRESS IF HOM	PHONE						
CITY STATE		Zip	MARITAL STATUS				
LAST NAME (GUARANTOR IF DIFFERENCE FROM ABOVE)		SOCIAL SECURITY #		BIRTHRATE			
EMPLOYER OF GUARANTOR (NAME AND FULL ADDRESS							
		MONTHLY GROSS PAY \$					
OTHER EMPLOYER (NAME AND FULL ADDRESS							
Phone			Monthly Gross Pay \$				
IF UNEMPLOYED, NAME OF LAST EMPLOYER AND FULL ADDRESS							
			LAST EMPI	LOYMENT DATE			
DEPENDENT FAMILY MEMBERS (IF MORE SPACE IS	BIRTHDATE	RELATIONSHIP	EMPLOYED BY	Employer			
NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER)				Phone			
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

RENT HOME			OTHER MONTHLY INCOME		
OWN HOME			\$		
			SPECIFY SOURCE		
OWED TO OTHERS TO WHOM OWED	PRESENT BALANCE	MONTHLY PAYMENT	ASSETS BANK NUMBER &ACCOUNT NUMBER	ACCOUNT BALANCE	
RENT/MORTGAGE			CHECKING		
UTILITIES			SAVINGS OR CERTIFICATE		
FOOD			403(B) OR 401(K)		
Auto Loan			STOCKS & BONDS		
	PRESENT BALANCE	MONTHLY PAYMENT	ASSETS BANK NUMBER & ACCOUNT NUMBER	ACCOUNT BALANCE	
CREDIT CARDS			IRA		
			Auto (Year & Make)		
			Auto (Year & Make)		
OTHER OBLIGATIONS (CHILD SUPPORT, ALIMONY, INSURANCE PAYMENTS)			RESIDENCE MARKET VALUE		
ADDITIONAL INFORMATION			Insurance Cash Value		
BILLS OWED TO OTHER MEDICAL PROVIDERS			OTHER ASSETS (DESCRIBE. E.G., SECOND HOME)		
Cost of Prescription Medication(s)					
TOTAL DEBTS			TOTAL ASSETS		
	CREDIT I	HISTORY I	CATION ARE TRUE AND COMPLETE. YOU A N ORDER TO EVALUATE THIS APPLICATION		

SIGNATURE

DATE